THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.102 "Commissioner" and "department" defined.

Sec. 102. (1) "Commissioner" as used in this act means the commissioner of the office of financial and insurance services.

(2) "Department" as used in this act means the office of financial and insurance services.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: Essential Insurance

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.224 Examinations and investigations of insurers; expenses; statement to insurers; employment of expert personnel; regulatory fees; expense of administering delinquency proceeding; definitions.

Sec. 224. (1) All actual and necessary expenses incurred in connection with the examination or other investigation of an insurer or other person regulated under the commissioner's authority shall be certified by the commissioner, together with a statement of the work performed including the number of days spent by the commissioner and each of the commissioner's deputies, assistants, employees, and others acting under the commissioner's authority. If correct, the expenses shall be paid to the persons by whom they were incurred, upon the warrant of the state treasurer payable from appropriations made by the legislature for this purpose.

(2) Except as otherwise provided in subsection (4), the commissioner shall prepare and present to the insurer or other person examined or investigated a statement of the expenses and reasonable cost incurred for each person engaged upon the examination or investigation, including amounts necessary to cover the pay and allowances granted to the persons by the Michigan civil service commission, and the administration and supervisory expense including an amount necessary to cover fringe benefits in conjunction with the examination or investigation. Except as otherwise provided in subsection (4), the insurer or other person, upon receiving the statement, shall pay to the commissioner the stated amount. The commissioner shall deposit the funds with the state treasurer as provided in section 225.

(3) The commissioner may employ attorneys, actuaries, accountants, investment advisers, and other expert personnel not otherwise employees of this state reasonably necessary to assist in the conduct of the examination or investigation or proceeding with respect to an insurer or other person regulated under the commissioner's authority at the insurer's or other person's expense except as otherwise provided in subsection (4). Except as otherwise provided in subsection (4), upon certification by the commissioner of the reasonable expenses incurred under this section, the insurer or other person examined or investigated shall pay those expenses directly to the person or firm rendering assistance to the commissioner. Expenses paid directly to such person or firm and the regulatory fees imposed by this section shall be examination expenses under section 22e of the single business tax act, 1975 PA 228, MCL 208.22e.

(4) An insurer is subject to a regulatory fee instead of the costs and expenses provided for in subsections (2) and (3). By June 30 of each year or within 30 days after the enactment into law of any appropriation for the insurance bureau's operation, the commissioner shall impose upon all insurers authorized to do business in this state a regulatory fee calculated as follows:

(a) As used in this subsection:

(*i*) "A" means total annuity considerations written in this state in the immediately preceding year.

(*ii*) "B" means base assessment rate. The base assessment rate shall not exceed .00038 and shall be a fraction the numerator of which is the total regulatory fee and the denominator of which is the total amount of direct underwritten premiums written in this state by all insurers for the immediately preceding calendar year as reported to the commissioner on the insurer's annual statements filed with the commissioner.

(*iii*) "I" means all direct underwritten premiums other than life insurance premiums and annuity considerations written in this state in the immediately preceding year by all insurers.

(*iv*) "L" means all direct underwritten life insurance premiums written in this state in the immediately preceding year by all life insurers.

(*v*) Total regulatory fee shall not exceed 80% of the gross appropriations for the insurance bureau's operation for a fiscal year and shall be the difference between the gross appropriations for the insurance bureau's operation for that current fiscal year and any restricted revenues, other than the regulatory fee itself, as identified in the gross appropriation for the insurance bureau's operation.

(*vi*) Direct premiums written in this state do not include any amounts that represent claims payments that are made on behalf of, or administrative fees that are paid in connection with, any administrative service contract, cost-plus arrangement, or any other noninsured or self-insured business.

(b) Two actual assessment rates shall be calculated so as to distribute 75% of the burden of the regulatory fee shortfall created by the exclusion of annuity considerations from the assessment base to life insurance and 25% to all other insurance. The 2 actual assessment rates shall be determined as follows:

(*i*) $\frac{L \times B + .75 \times B \times A}{L}$ = assessment rate for life insurance.

(*ii*) $\frac{I \times B + .25 \times B \times A}{I}$ = assessment rate for insurance other than life insurance.

(c) Each insurer's regulatory fee shall be a minimum fee of $250.00 and shall be determined by multiplying the actual assessment rate by the assessment base of that insurer as determined by the commissioner from the insurer's annual statement for the immediately preceding calendar year filed with the commissioner.

(5) Not less than 67% of the revenue derived from the regulatory fee under subsection (4) shall be used for the regulation of financial conduct of persons regulated under the commissioner's authority and for the regulation of persons regulated under the commissioner's authority engaged in the business of health care and health insurance in this state.

(6) The amount, if any, by which amounts credited to the commissioner pursuant to section 225 exceed actual expenditures pursuant to appropriations for the insurance bureau's operation for a fiscal year shall be credited toward the appropriation for the insurance bureau in the next fiscal year.

(7) All money paid into the state treasury by an insurer under this section shall be credited as provided under section 225.

(8) A regulatory fee under this section shall not be treated by an insurer as a levy or excise upon premium but as a regulatory burden that is apportioned in relation to insurance activity in this state and reflects the insurance regulatory burden on this state as a result of this insurance activity. A foreign or alien insurer authorized to do business in this state may consider the liability required under this section as a burden imposed by this state in the calculation of the insurer's liability required under section 476a.

(9) An insurer may file with the commissioner a protest to the regulatory fee imposed not later than 15 days after receipt of the regulatory fee. The commissioner shall review the grounds for the protest and shall hold a conference with the insurer at the insurer's request. The commissioner shall transmit his or her findings to the insurer with a restatement of the regulatory fee based upon the findings. Statements of regulatory fees to which protests have not been made and restatements of regulatory fees are due and shall be paid not later than 30 days after their receipt. Regulatory fees that are not paid when due bear interest on the unpaid fee which shall be calculated at 6-month intervals from the date the fee was due at a rate of interest equal to 1% plus the average interest rate paid at auctions of 5-year United States treasury notes during the 6 months immediately preceding July 1 and January 1, as certified by the state treasurer, and compounded annually, until the assessment is paid in full. An insurer who fails to pay its regulatory fee within the prescribed time limits may have its certificate of authority or license suspended, limited, or revoked as the commissioner considers warranted until the regulatory fee is paid. If the commissioner determines that a regulatory fee or a part of a regulatory fee paid by an insurer is in excess of the amount legally due and payable, the amount of the excess shall be refunded or, at the insurer's option, be applied as a credit against the regulatory fee for the next fiscal year. An overpayment of $100.00 or less shall be applied as a credit against the insurer's regulatory fee for the next fiscal year unless the insurer had a $100.00 or less overpayment in the immediately preceding fiscal year. If the insurer had a $100.00 or less overpayment in the immediately preceding fiscal year, at the insurer's option, the current fiscal year overpayment of $100.00 or less shall be refunded.

(10) Any amounts stated and presented to or certified, assessed, or imposed upon an insurer as provided in subsections (2), (3), and (4) that are unpaid as of the date that the insurer is subjected to a delinquency proceeding pursuant to chapter 81 shall be regarded as an expense of administering the delinquency proceeding and shall be payable as such from the general assets of the insurer.

(11) In addition to the regulatory fee provided in subsection (4), each insurer that locates records or personnel knowledgeable about those records outside this state pursuant to section 476a(3) or section 5256 shall reimburse the insurance bureau for expenses and reasonable costs incurred by the insurance bureau as a result of travel and other costs related to examinations or investigations of those records or personnel. The reimbursement shall not include any costs that the insurance bureau would have incurred if the examination had taken place in this state.

(12) As used in this section:

(a) "Annuity considerations" means receipts on the sale of annuities as used in section 22a of the single business tax act, 1975 PA 228, MCL 208.22a.

(b) "Insurer" means an insurer authorized to do business in this state and includes nonprofit health care corporations, dental care corporations, and health maintenance organizations.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1958, Act 196, Imd. Eff. Apr. 21, 1958;—Am. 1968, Act 275, Imd. Eff. July 1, 1968;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 228, Imd. Eff. June 30, 1994;—Am. 1998, Act 121, Imd. Eff. June 10, 1998;—Am. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2001, Act 143, Imd. Eff. Oct. 26, 2001.

Popular name: Act 218

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.240 Fees and charges; collection, payment, and disposition.

Sec. 240. (1) The commissioner shall collect, and the person affected shall pay to the commissioner, the following fees:

(a) Filing fee for original authorization to transact insurance or health maintenance organization business in this state, for each domestic, foreign, and alien insurer, and each health maintenance organization	$ 25.00.
(b) Filing fee for annual statement of foreign and alien insurers, each year, subject to section 476a	$ 25.00.
(c) Agent's appointment fee, resident or nonresident, payable by insurer or health maintenance organization so represented, for each agent, each year	$ 5.00.
(d) Application fee payable by each initial applicant for license as resident agent, nonresident agent, surplus lines agent, solicitor, counselor, or adjuster, not transferable or refundable	$ 10.00.
(e) Solicitor's license, each year	$ 10.00.
(f) Insurance counselor license, each year	$ 10.00.
(g) Adjuster's license, each year	$ 5.00.
(h) License examination fee, payable by applicant for all subjects covered in any 1 examination, or portion of an examination, for license as resident agent, surplus lines agent, solicitor, counselor, or adjuster, each examination, not transferable or refundable	$ 10.00.
(i) Surplus lines agent license each year	$100.00.

(2) Each incorporated domestic insurer shall pay to the attorney general, for the examination of the insurer's articles of incorporation or any amendments to the articles of incorporation, the sum of $25.00.

(3) The fees and charges for official services performed by the commissioner or the commissioner's deputies or employees, when collected, shall be turned over to the state treasurer and a receipt taken. The fees and charges provided for in this section shall be deposited in the state treasury to the credit of the general fund.

(4) The provisions of subsection (1)(h), insofar as they provide for examination fees, are applicable only if the examinations are administered by the commissioner. If the examinations are administered by some designated authority other than the commissioner, appropriate examination fees shall be payable directly to the designated authority.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1967, Act 221, Imd. Eff. July 10, 1967;—Am. 1979, Act 181, Imd. Eff. Dec. 18, 1979;—Am. 1981, Act 1, Imd. Eff. Mar. 30, 1981;—Am. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.2213 Internal formal grievance procedure; approval by commissioner; contents; person authorized to act on behalf of insured or enrollee; section inapplicable to provider complaint and insurance listed in right to independent review act; definitions.

Sec. 2213. (1) Except as otherwise provided in subsection (4), each insurer and health maintenance organization shall establish an internal formal grievance procedure for approval by the commissioner for persons covered under a policy, certificate, or contract issued under chapter 34, 35, or 36 that includes all of the following:

(a) Provides for a designated person responsible for administering the grievance system.

(b) Provides a designated person or telephone number for receiving complaints.

(c) Ensures full investigation of a complaint.

(d) Provides for timely notification in plain English to the insured or enrollee as to the progress of an investigation.

(e) Provides an insured or enrollee the right to appear before the board of directors or designated committee or the right to a managerial-level conference to present a grievance.

(f) Provides for notification in plain English to the insured or enrollee of the results of the insurer's or health maintenance organization's investigation and for advisement of the insured's or enrollee's right to review the grievance by the commissioner or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(g) Provides summary data on the number and types of complaints and grievances filed. Beginning April 15, 2001, this summary data for the prior calendar year shall be filed annually with the commissioner on forms provided by the commissioner.

(h) Provides for periodic management and governing body review of the data to assure that appropriate actions have been taken.

(i) Provides for copies of all complaints and responses to be available at the principal office of the insurer or health maintenance organization for inspection by the commissioner for 2 years following the year the complaint was filed.

(j) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(k) That a final determination will be made in writing by the insurer or health maintenance organization not later than 35 calendar days after a formal grievance is submitted in writing by the insured or enrollee. The timing for the 35-calendar-day period may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business days if the insurer or health maintenance organization has not received requested information from a health care facility or health professional.

(*l*) That a determination will be made by the insurer or health maintenance organization not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer or health maintenance organization is made orally, the insurer or health maintenance organization shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) As used in this section:

(a) “Adverse determination” means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

(b) “Grievance” means a complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

(*i*) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(*ii*) Benefits or claims payment, handling, or reimbursement for health care services.

(*iii*) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer or health maintenance organization.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 707, Imd. Eff. Dec. 30, 2002.

Popular name: Act 218

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3501 Definitions.

Sec. 3501. As used in this chapter:

(a) "Affiliated provider" means a health professional, licensed hospital, licensed pharmacy, or any other institution, organization, or person having a contract with a health maintenance organization to render 1 or more health maintenance services to an enrollee.

(b) "Basic health services" means:

(*i*) Physician services including consultant and referral services by a physician, but not including psychiatric services.

(*ii*) Ambulatory services.

(*iii*) Inpatient hospital services, other than those for the treatment of mental illness.

(*iv*) Emergency health services.

(*v*) Outpatient mental health services, not fewer than 20 visits per year.

(*vi*) Intermediate and outpatient care for substance abuse as follows:

(A) For group contracts, if the fees for a group contract would be increased by 3% or more because of the provision of services under this subparagraph, the group subscriber may decline the services. For individual contracts, if the total fees for all individual contracts would be increased by 3% or more because of the provision of the services required under this subparagraph in all of those contracts, the named subscriber of each contract may decline the services.

(B) Charges, terms, and conditions for the services required to be provided under this subparagraph shall not be less favorable than the maximum prescribed for any other comparable service.

(C) The services required to be provided under this subparagraph shall not be reduced by terms or conditions that apply to other services in a group or individual contract. This sub-subparagraph shall not be construed to prohibit contracts that provide for deductibles and copayment provisions for services for intermediate and outpatient care for substance abuse.

(D) The services required to be provided under this subparagraph shall, at a minimum, provide for up to $2,968.00 in services for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(E) As used in this subparagraph, "intermediate care", "outpatient care", and "substance abuse" have those meanings ascribed to them in section 3425.

(*vii*) Diagnostic laboratory and diagnostic and therapeutic radiological services.

(*viii*) Home health services.

(*ix*) Preventive health services.

(c) "Credentialing verification" means the process of obtaining and verifying information about a health professional and evaluating that health professional when that health professional applies to become a participating provider with a health maintenance organization.

(d) "Enrollee" means an individual who is entitled to receive health maintenance services under a health maintenance contract.

(e) "Health maintenance contract" means a contract between a health maintenance organization and a subscriber or group of subscribers, to provide, when medically indicated, designated health maintenance services, as described in and pursuant to the terms of the contract, including, at a minimum, basic health maintenance services. Health maintenance contract includes a prudent purchaser contract.

(f) "Health maintenance organization" means an entity that does the following:

(*i*) Delivers health maintenance services that are medically indicated to enrollees under the terms of its health maintenance contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services.

(*ii*) Is responsible for the availability, accessibility, and quality of the health maintenance services provided.

(g) "Health maintenance services" means services provided to enrollees of a health maintenance organization under their health maintenance contract.

(h) “Health professional” means an individual licensed, certified, or authorized in accordance with state law to practice a health profession in his or her respective state.

(i) “Primary verification” means verification by the health maintenance organization of a health professional's credentials based upon evidence obtained from the issuing source of the credential.

(j) “Prudent purchaser contract” means a contract offered by a health maintenance organization to groups or to individuals under which enrollees who select to obtain health care services directly from the organization or through its affiliated providers receive a financial advantage or other advantage by selecting those providers.

(k) “Secondary verification” means verification by the health maintenance organization of a health professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential.

(*l*) “Service area” means a defined geographical area in which health maintenance services are generally available and readily accessible to enrollees and where health maintenance organizations may market their contracts.

(m) “Subscriber” means an individual who enters into a health maintenance contract, or on whose behalf a health maintenance contract is entered into, with a health maintenance organization that has received a certificate of authority under this chapter and to whom a health maintenance contract is issued.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3503 Applicability of provisions to health maintenance organization.

Sec. 3503. (1) All of the provisions of this act that apply to a domestic insurer authorized to issue an expense-incurred hospital, medical, or surgical policy or certificate, including, but not limited to, sections 223 and 7925 and chapters 34 and 36, apply to a health maintenance organization under this chapter unless specifically excluded, or otherwise specifically provided for in this chapter.

(2) Sections 408, 410, 411, 901, and 5208, chapter 77, and, except as otherwise provided in subsection (1), chapter 79 do not apply to a health maintenance organization.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2006, Act 366, Imd. Eff. Sept. 18, 2006.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3505 Certificate of authority; use of descriptive words; restrictions.

Sec. 3505. (1) A health maintenance organization shall receive a certificate of authority under this chapter before issuing health maintenance contracts. A health maintenance organization license issued under former part 210 of the public health code, 1978 PA 368, automatically becomes a certificate of authority under this chapter on the effective date of this chapter.

(2) “Health maintenance organization” shall not be used to describe or refer to any entity or person and an entity or person shall not use any other descriptive words that may mislead, deceive, or imply that it is a health maintenance organization, unless the entity or person has a certificate of authority as a health maintenance organization under this chapter.

(3) A health maintenance organization shall not use in its name, contracts, or literature the words “insurance”, “casualty”, “surety”, “mutual”, or any other words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of an insurance or surety corporation doing business in this state.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3507 Authorizing and regulating health maintenance organization; establishment of system by commissioner.

Sec. 3507. The commissioner shall establish a system of authorizing and regulating health maintenance organizations in this state to protect and promote the public health through the assurance that the organizations provide:

(a) An acceptable quality of health care by qualified personnel.

(b) Health care facilities, equipment, and personnel that may reasonably be required to economically provide health maintenance services.

(c) Operational arrangements that integrate the delivery of various services.

(d) A financially sound prepayment plan for meeting health care costs.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3508 Quality assessment program; quality improvement program.

Sec. 3508. (1) A health maintenance organization shall develop and maintain a quality assessment program to assess the quality of health care provided to enrollees that includes, at a minimum, systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements. A health maintenance organization shall make available its quality assessment program as prescribed by the commissioner.

(2) A health maintenance organization shall establish and maintain a quality improvement program to design, measure, assess, and improve the processes and outcomes of health care as identified in the program. A health maintenance organization shall make available its quality improvement program as prescribed by the commissioner. The quality improvement program shall be under the direction of the health maintenance organization's medical director and shall include:

(a) A written statement of the program's objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, and performance improvement activities.

(b) An annual effectiveness review of the program.

(c) A written quality improvement plan that, at a minimum, describes how the health maintenance organization analyzes both the processes and outcomes of care, identifies the targeted diagnoses and treatments to be reviewed each year, uses a range of appropriate methods to analyze quality, compares program findings with past performance and internal goals and external standards, measures the performance of affiliated providers, and conducts peer review activities.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3509 Certificate of authority; application; form; limitation; change of service area.

Sec. 3509. (1) An application to the commissioner for a certificate of authority shall be on a form prescribed and provided by the commissioner.

(2) A certificate of authority issued under this chapter is limited to the service area described in the application upon which the certificate of authority was issued.

(3) A health maintenance organization seeking to change the approved service area shall submit an application to change service area to the commissioner and shall not change the service area until approval is received. The commissioner shall specify the information required to be in the application under this subsection.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3511 Governing body; election of enrollee board members; terms; vacancy; meetings.

Sec. 3511. (1) By the end of the first 12 months of operation, a health maintenance organization's governing body shall have a minimum of 1/3 of its membership consisting of adult enrollees of the

organization who are not compensated officers, employees, stockholders who own more than 5% of the organization's shares, or other individuals responsible for the conduct of, or financially interested in, the organization's affairs. The enrollee board members shall be elected by a simple plurality of the voting subscribers. Each subscriber shall have 1 vote. The enrollee board members shall hold office for 3 years after their election, except that the terms of office following the first enrollee election may be adjusted to allow the terms of enrollee board members to expire on a staggered basis. A vacancy among enrollee board members shall be filled by appointment by a simple majority of the remaining enrollee members of the board from individuals meeting the qualifications of this section. A vacancy shall be filled only for the unexpired portion of the original term, at which time the enrollee member shall be elected in the manner prescribed by this chapter.

(2) A health maintenance organization's governing body shall meet at least quarterly unless specifically exempted from this requirement by the commissioner.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3513 Health delivery and business and financial operations; regulation by commissioner.

Sec. 3513. (1) The commissioner shall regulate health delivery aspects of health maintenance organization operations for the purpose of assuring that health maintenance organizations are capable of providing care and services promptly, appropriately, and in a manner that assures continuity and acceptable quality of health care. The commissioner shall encourage health maintenance organizations to utilize a wide variety of health-related disciplines and facilities and to develop services that contribute to the prevention of disease and disability and to the restoration of health.

(2) The commissioner shall regulate the business and financial aspects of health maintenance organization operations for the purpose of assuring that the organizations are financially sound and follow acceptable business practices. The commissioner shall assure that the organizations operate in the interest of enrollees consistent with overall health care cost containment while delivering acceptable quality of care and services that are available and accessible to enrollees with appropriate administrative costs and health care provider incentives. A health maintenance organization shall do all of the following:

(a) Provide, as promptly as appropriate, health maintenance services in a manner that assures continuity and imparts quality health care under conditions the commissioner considers to be in the public interest.

(b) Provide, within the geographic area served by the health maintenance organization, health maintenance services that are available, accessible, and provided as promptly as appropriate to each of its enrollees in a manner that assures continuity, and are available and accessible to enrollees 24 hours a day and 7 days a week for the treatment of emergency episodes of illness or injury.

(c) Provide adequate arrangements for a continuous evaluation of the quality of health care.

(d) Provide that reasonable provisions exist for an enrollee to obtain emergency health services both within and outside of the geographic area served by the health maintenance organization.

(e) Provide that reasonable procedures exist for resolving enrollee grievances as required by this chapter or as otherwise provided by law.

(f) Be incorporated as a distinct legal entity under the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098, the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, or the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200.

(g) Have a governing body that meets the requirements of this chapter.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3515 Additional health maintenance services; copayments; limitation; report on increase of employer and employee numbers; "preventive health care services" defined; partial payment from government or private person.

Sec. 3515. (1) A health maintenance organization may provide additional health maintenance services or any other related health care service or treatment not required under this chapter.

(2) A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health maintenance contracts that include copayments, stated as dollar amounts for the cost of covered services, and coinsurance, stated as percentages for the cost of covered services. Coinsurance for basic health services, excluding deductibles, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee and shall not be based on the provider's standard charge for the service. This subsection does not limit the commissioner's authority to regulate and establish fair, sound, and reasonable copayment and coinsurance limits including out of pocket maximums.

(3) By May 15, 2008, and by each May 15 after 2008, the commissioner shall make a determination as to whether the greater copayment and coinsurance levels allowed by the amendatory act that added this subsection have increased the number of employers who have contracted for health maintenance organization services and whether these levels have increased the number of enrollees receiving health maintenance organization services. In making this determination, the commissioner shall hold a public hearing by February 1, 2008, and may hold a public hearing thereafter, shall seek the advice and input from appropriate independent sources, including, but not limited to, all health maintenance organizations operating in this state and with enrollees in this state, and shall issue a report delineating specific examples of copayment and coinsurance levels in force and suggestions to increase the number of persons enrolled in health maintenance organizations.

(4) If the results of the report issued under subsection (3) are disputed or if the commissioner determines that the circumstances that the report was based on have changed, the commissioner shall issue a supplemental report to the report under subsection (3) that includes copies of the written objections disputing the commissioner's report determinations or that specifies the change of circumstances. The supplemental report shall be issued not later than December 15 immediately following the release of the report under subsection (3) that this report supplements and shall be supported by substantial evidence.

(5) All of the following shall be considered by the commissioner for purposes of subsections (3) and (4):

(a) Information and data gathered from health maintenance organizations regarding the effects of greater copayment and coinsurance levels allowed by the amendatory act that added this subsection.

(b) Information and data provided by employers who employ residents of this state.

(c) Any other information and data the commissioner considers relevant.

(6) The reports and certifications required under subsections (3) and (4) shall be forwarded to the governor, the clerk of the house of representatives, the secretary of the senate, and all members of the senate and house of representatives standing committees on insurance and health issues.

(7) A health maintenance organization shall not require contributions be made to a deductible for preventive health care services. As used in this subsection, "preventive health care services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability.

(8) A health maintenance organization may accept from governmental agencies and from private persons payments covering any part of the cost of health maintenance contracts.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3517 Healthy lifestyle programs; emergency or out-of-area service; payment of expenses or fees.

Sec. 3517. (1) A health maintenance contract shall not provide for payment of cash or other material benefit to an enrollee, except as stated in this chapter.

(2) Subsection (1) does not prohibit a health maintenance organization from promoting optimum health by offering to all currently enrolled subscribers or to all currently covered enrollees 1 or more healthy lifestyle programs. A "healthy lifestyle program" means a program recognized by a health maintenance organization that enhances health or reduces risk of disease, including, but not limited to, promoting nutrition and physical exercise and compliance with disease management programs and preventive service guidelines that are supported by evidence-based medical practice. Subsection (1) does not prohibit a health maintenance

organization from offering a currently enrolled subscriber or currently covered enrollee goods, vouchers, or equipment that supports achieving optimal health goals. An offering of goods, vouchers, or equipment under this subsection is not a violation of subsection (1) and shall not be considered valuable consideration, a material benefit, a gift, a rebate, or an inducement under this act.

(3) For an emergency episode of illness or injury that requires immediate treatment before it can be secured through the health maintenance organization, or for an out-of-area service specifically authorized by the health maintenance organization, an enrollee may utilize a provider within or without this state not normally engaged by the health maintenance organization to render service to its enrollees. The organization shall pay reasonable expenses or fees to the provider or enrollee as appropriate in an individual case. These transactions are not considered acts of insurance and, except as provided in this chapter and section 3406k, are not otherwise subject to this act.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3519 Contract and contract rates; fairness; rate differential; basic health services required.

Sec. 3519. (1) A health maintenance organization contract and the contract's rates, including any deductibles, copayments, and coinsurances, between the organization and its subscribers shall be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts shall not be unfairly discriminatory.

(2) A health maintenance organization contract and the contract's rates shall not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The commissioner may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential is supported by sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new coverages. A healthy lifestyle program as defined in section 3517(2) is not subject to the commissioner's approval under this subsection and is not required to be supported by sound actuarial principles, a reasonable classification system, or be related to actual and credible loss statistics or reasonably anticipated experience for new coverages.

(3) All health maintenance organization contracts shall include, at a minimum, basic health services.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3521 Prepayment rates; filing and approval of methodology; schedule.

Sec. 3521. (1) The methodology used to determine prepayment rates by category rates charged by the health maintenance organization and any changes to either the methodology or the rates shall be filed with and approved by the commissioner before becoming effective.

(2) A health maintenance organization shall submit supporting data used in the development of a prepayment rate or rating methodology and all other data sufficient to establish the financial soundness of the prepayment plan or rating methodology.

(3) The commissioner may annually require a schedule of rates for all subscriber contracts and riders. All submissions shall note changes of rates previously filed or approved.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3523 Health maintenance contract; provisions.

Sec. 3523. (1) A health maintenance contract shall be filed with and approved by the commissioner.

(2) A health maintenance contract shall include any approved riders, amendments, and the enrollment application.

(3) In addition to the provisions of this act that apply to an expense-incurred hospital, medical, or surgical policy or certificate, a health maintenance contract shall include all of the following:

(a) Name and address of the organization.

(b) Definitions of terms subject to interpretation.

(c) The effective date and duration of coverage.

(d) The conditions of eligibility.

(e) A statement of responsibility for payments.

(f) A description of specific benefits and services available under the contract within the service area, with respective copayments, coinsurances, and deductibles.

(g) A description of emergency and out-of-area services.

(h) A specific description of any limitation, exclusion, and exception, including any preexisting condition limitation, grouped together with captions in boldfaced type.

(i) Covenants that address confidentiality, an enrollee's right to choose or change the primary care physician or other providers, availability and accessibility of services, and any rights of the enrollee to inspect and review his or her medical records.

(j) Covenants of the subscriber shall address all of the following subjects:

(*i*) Timely payment.

(*ii*) Nonassignment of benefits.

(*iii*) Truth in application and statements.

(*iv*) Notification of change in address.

(*v*) Theft of membership identification.

(k) A statement of responsibilities and rights regarding the grievance procedure.

(*l*) A statement regarding subrogation and coordination of benefits provisions, including any responsibility of the enrollee to cooperate.

(m) A statement regarding conversion rights.

(n) Provisions for adding new family members or other acquired dependents, including conversion of individual contracts to family contracts and family contracts to individual contracts, and the time constraints imposed.

(o) Provisions for grace periods for late payment.

(p) A description of any specific terms under which the health maintenance organization or the subscriber can terminate the contract.

(q) A statement of the nonassignability of the contract.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3525 Proposal to revise contract; approval of commissioner; approval with modifications; hearing; disposition; exception; notice.

Sec. 3525. (1) Except as otherwise provided in subsection (2), if a health maintenance organization desires to change a contract it offers to enrollees or desires to change a rate charged, a copy of the proposed revised contract or rate shall be filed with the commissioner and shall not take effect until 60 days after the filing, unless the commissioner approves the change in writing before the expiration of 60 days after the filing. If the commissioner considers that the proposed revised contract or rate is illegal or unreasonable in relation to the services provided, the commissioner, not more than 60 days after the proposed revised contract or rate is filed, shall notify the organization in writing, specifying the reasons for disapproval or for approval with modifications. For an approval with modifications, the notice shall specify what modifications in the filing are required for approval, the reasons for the modifications, and that the filing becomes effective after the modifications are made and approved by the commissioner. The commissioner shall schedule a hearing not more than 30 days after receipt of a written request from the health maintenance organization, and the revised contract or rate shall not take effect until approved by the commissioner after the hearing. Within 30 days

after the hearing, the commissioner shall notify the organization in writing of the disposition of the proposed revised contract or rate, together with the commissioner's findings of fact and conclusions.

(2) If the revised contract or rate is the result of collective bargaining and affects only the members of the groups engaged in the collective bargaining, subsection (1) does not apply but the revised contract or rate shall be immediately filed with the commissioner.

(3) Not less than 30 days before the effective date of a proposed change in a health maintenance contract or the rate charged, the health maintenance organization shall issue to each subscriber or group of subscribers who will be affected by the proposed change a clear written statement stating the extent and nature of the proposed change. If the commissioner has approved a proposed change in a contract or rate in writing before the expiration of 60 days after the date of filing, the organization immediately shall notify each subscriber or group of subscribers who will be affected by the proposed change.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3527 Health maintenance contract; performance; violation of terms.

Sec. 3527. (1) Upon obtaining a certificate of authority, a health maintenance organization may enter into health maintenance contracts and engage in other activities consistent with this chapter and other applicable laws of this state that are necessary to perform its obligations under its contracts.

(2) A health maintenance organization shall not terminate a health maintenance contract or deny a renewal of a contract because of age, sex, health status, national origin, or frequency of utilization of medically indicated services of an enrollee or group of enrollees.

(3) A health maintenance contract may be terminated for violation of the terms of the contract or for nonpayment of the fixed prepaid sum or per capita prepayment set forth in the contract if the fixed prepaid sum or per capita prepayment is not paid within 30 days after the due date.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3528 Health maintenance organization; duties.

Sec. 3528. (1) A health maintenance organization shall do all of the following:

(a) Establish written policies and procedures for credentialing verification of all health professionals with whom the health maintenance organization contracts and shall apply these standards consistently.

(b) Verify the credentials of a health professional before entering into a contract with that health professional. The health maintenance organization's medical director or other designated health professional shall have responsibility for, and shall participate in, health professional credentialing verification.

(c) Establish a credentialing verification committee consisting of licensed physicians and other health professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification.

(d) Make available for review by the applying health professional upon written request all application and credentialing verification policies and procedures.

(e) Retain all records and documents relating to a health professional's credentialing verification process for at least 2 years.

(f) Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

(2) A health maintenance organization shall obtain primary verification of at least all of the following information about an applicant to become a health professional with the health maintenance organization:

(a) Current license to practice in this state and history of licensure.

(b) Current level of professional liability coverage, if applicable.

(c) Status of hospital privileges, if applicable.

(3) A health maintenance organization shall obtain, subject to either primary or secondary verification at the health maintenance organization's discretion, all of the following information about an applicant to become an affiliated provider with the health maintenance organization:

(a) The health professional's license history in this and all other states.
(b) The health professional's malpractice history.
(c) The health professional's practice history.
(d) Specialty board certification status, if applicable.
(e) Current drug enforcement agency (DEA) registration certificate, if applicable.
(f) Graduation from medical or other appropriate school.
(g) Completion of postgraduate training, if applicable.

(4) A health maintenance organization shall obtain at least every 3 years primary verification of all of the following for a participating health professional:

(a) Current license to practice in this state.
(b) Current level of professional liability coverage, if applicable.
(c) Status of hospital privileges, if applicable.

(5) A health maintenance organization shall require all participating providers to notify the health maintenance organization of changes in the status of any of the items listed in this section at any time and identify for providers the individual at the health maintenance organization to whom they should report changes in the status of an item listed in this section.

(6) A health maintenance organization shall provide a health professional with the opportunity to review and correct information submitted in support of that health professional's credentialing verification application as follows:

(a) Each health professional who is subject to the credentialing verification process has the right to review all information, including the source of that information, obtained by the health maintenance organization to satisfy the requirements of this section during the health maintenance organization's credentialing process.

(b) A health maintenance organization shall notify a health professional of any information obtained during the health maintenance organization's credentialing verification process that does not meet the health maintenance organization's credentialing verification standards or that varies substantially from the information provided to the health maintenance organization by the health professional, except that the health maintenance organization is not required to reveal the source of information if the information is not obtained to meet the requirements of this section or if disclosure is prohibited by law.

(c) A health professional has the right to correct any erroneous information. A health maintenance organization shall have a formal process by which a health professional may submit supplemental or corrected information to the health maintenance organization's credentialing verification committee and request a reconsideration of the health professional's credentialing verification application if the health professional feels that the health carrier's credentialing verification committee has received information that is incorrect or misleading. Supplemental information is subject to confirmation by the health maintenance organization.

(7) If a health maintenance organization contracts to have another entity perform the credentialing functions required by this section, the commissioner shall hold the health maintenance organization responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of this section are met.

(8) Nothing in this act shall be construed to require a health maintenance organization to select a provider as a participating provider solely because the provider meets the health maintenance organization's credentialing verification standards, or to prevent a health maintenance organization from utilizing separate or additional criteria in selecting the health professionals with whom it contracts.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002.

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THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3529 Affiliated provider contracts; collection of payments from enrollees; contract provisions; waiver of requirement under subsection (2); contract format; evidence of sufficient number of providers.

Sec. 3529. (1) A health maintenance organization may contract with or employ health professionals on the basis of cost, quality, availability of services to the membership, conformity to the administrative procedures of the health maintenance organization, and other factors relevant to delivery of economical, quality care, but shall not discriminate solely on the basis of the class of health professionals to which the health professional belongs.

(2) A health maintenance organization shall enter into contracts with providers through which health care

services are usually provided to enrollees under the health maintenance organization plan.

(3) An affiliated provider contract shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments, coinsurances, and deductibles directly from enrollees.

(4) An affiliated provider contract shall contain provisions assuring all of the following:

(a) The provider meets applicable licensure or certification requirements.

(b) Appropriate access by the health maintenance organization to records or reports concerning services to its enrollees.

(c) The provider cooperates with the health maintenance organization's quality assurance activities.

(5) The commissioner may waive the contract requirement under subsection (2) if a health maintenance organization has demonstrated that it is unable to obtain a contract and accessibility to patient care would not be compromised. When 10% or more of a health maintenance organization's elective inpatient admissions, or projected admissions for a new health maintenance organization, occur in hospitals with which the health maintenance organization does not have contracts or agreements that protect enrollees from liability for authorized admissions and services, the health maintenance organization may be required to maintain a hospital reserve fund equal to 3 months' projected claims from such hospitals.

(6) A health maintenance organization shall submit to the commissioner for approval standard contract formats proposed for use with its affiliated providers and any substantive changes to those contracts. The contract format or change is considered approved 30 days after filing unless approved or disapproved within the 30 days. As used in this subsection, "substantive changes to contract formats" means a change to a provider contract that alters the method of payment to a provider, alters the risk assumed by each party to the contract, or affects a provision required by law.

(7) A health maintenance organization or applicant shall provide evidence that it has employed, or has executed affiliation contracts with, a sufficient number of providers to enable it to deliver the health maintenance services it proposes to offer.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

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THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3530 Availability of covered services; assurance; establishment and maintenance of proximity.

Sec. 3530. (1) A health maintenance organization shall maintain contracts with those numbers and those types of affiliated providers that are sufficient to assure that covered services are available to its enrollees without unreasonable delay. The commissioner shall determine what is sufficient as provided in this section and as may be established by reference to reasonable criteria used by the health maintenance organization, including, but not limited to, provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(2) If a health maintenance organization has an insufficient number or type of participating providers to provide a covered benefit, the health maintenance organization shall ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the commissioner.

(3) A health maintenance organization shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees. In determining whether a health maintenance organization has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3531 Contracts with health care providers to become affiliated providers; requirements; standards; filing; duplicative standards; notice procedures; provider application period; approval or rejection as affiliated provider; termination of contract; providing information to insurer.

Sec. 3531. (1) This section applies if a health maintenance organization contracts with health care providers to become affiliated providers or offers a prudent purchaser contract.

(2) A health maintenance organization may enter into a contract with 1 or more health care providers to control health care costs, assure appropriate utilization of health maintenance services, and maintain quality of health care. The health maintenance organization may limit the number of contracts entered into under this section if the number of contracts is sufficient to assure reasonable levels of access to health maintenance services for recipients of those services. The number of contracts authorized by this section that are necessary to assure reasonable levels of access to health maintenance services for recipients shall be determined by the health maintenance organization as approved by the commissioner under this chapter. However, the health maintenance organization shall offer a contract, comparable to those contracts entered into with other affiliated providers, to at least 1 health care provider that provides the applicable health maintenance services and is located within a reasonable distance from the recipients of those health maintenance services, if a health care provider that provides the applicable health maintenance services is located within that reasonable distance.

(3) A health maintenance organization shall give all health care providers that provide the applicable health maintenance services and are located in the geographic area served by the health maintenance organization an opportunity to apply to the health maintenance organization to become an affiliated provider.

(4) A contract shall be based upon the following written standards which shall be filed by the health maintenance organization with the commissioner on a form and in a manner that is uniformly developed and applied by the commissioner:

(a) Standards for maintaining quality health care.

(b) Standards for controlling health care costs.

(c) Standards for assuring appropriate utilization of health care services.

(d) Standards for assuring reasonable levels of access to health care services.

(e) Other standards considered appropriate by the health maintenance organization.

(5) If the commissioner determines that standards under subsection (4) are duplicative of standards already filed by the health maintenance organization, those duplicative standards need not be filed under subsection (4).

(6) A health maintenance organization shall develop and institute procedures that are designed to notify health care providers that provide the applicable health maintenance services and are located in the geographic area served by the organization of the acceptance of applications for a provider panel. The procedures shall include the giving of notice to those providers upon request and shall include publication in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the initial provider application period.

(7) A health maintenance organization shall provide for an initial 60-day provider application period during which providers may apply to the health maintenance organization to become affiliated providers. A health maintenance organization that has entered into a contract with an affiliated provider shall provide, at least once every 4 years, for a 60-day provider application period during which a provider may apply to the organization to become an affiliated provider. Notice of this provider application period shall be given to providers upon request and shall be published in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the commencement of the provider application period. Upon receipt of a request by a health care provider, the organization shall provide the written standards required under this chapter to the health care provider. Within 90 days after the close of a provider application period, or within 30 days following the completion of the applicable physician credentialing process, whichever is later, a health maintenance organization shall notify an applicant in writing as to whether the application to become an affiliated provider has been accepted or rejected. If an applicant has been rejected, the health maintenance organization shall state in writing the reasons for rejection, citing 1 or more of the standards.

(8) A health care provider whose contract as an affiliated provider is terminated shall be provided upon request with a written explanation by the organization of the reasons for the termination.

(9) A health maintenance organization that is providing prudent purchaser agreement services to an insurer shall provide the insurer on a timely basis with information requested by the insurer that the organization has and that the insurer needs to comply with section 2212.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

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THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3533 Prudent purchaser contracts; reimbursement for unauthorized services or services by nonaffiliated providers; rate and operating requirements; maintenance of financial records by health maintenance organization.

Sec. 3533. (1) A health maintenance organization may offer prudent purchaser contracts to groups or individuals and in conjunction with those contracts a health maintenance organization may pay or may reimburse enrollees, or may contract with another entity to pay or reimburse enrollees, for unauthorized services or for services by nonaffiliated providers in accordance with the terms of the contract and subject to copayments, coinsurances, deductibles, or other financial penalties designed to encourage enrollees to obtain services from the organization's providers.

(2) Prudent purchaser contracts and the rates charged for them are subject to the same regulatory requirements as health maintenance contracts. The rates charged by an organization for coverage under contracts issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the organization for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(3) A health maintenance organization shall not issue prudent purchaser contracts unless it is in full compliance with the requirements for adequate working capital, statutory deposits, and reserves as provided in this chapter and it is not operating under any limitation to its authorization to do business in this state.

(4) A health maintenance organization shall maintain financial records for its prudent purchaser contracts and activities in a form separate or separable from the financial records of other operations and activities carried on by the organization.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3535 Solicitation or advertising.

Sec. 3535. Solicitation of enrollees or advertising of the services, charges, or other nonprofessional aspects of the health maintenance organization's operation under this section shall not be construed to be in violation of laws relating to solicitation or advertising by health professionals, but shall not include advertising that makes any qualitative judgment as to a health professional who provides services for a health maintenance organization. A solicitation or advertising shall not offer a material benefit or other thing of value as an inducement to prospective subscribers other than the services of the organization.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3537 Open enrollment period; acceptance of group members; rating nongroup membership.

Sec. 3537. (1) After the initial 24 months of operation, a health maintenance organization shall have an open enrollment period of not less than 30 days at least once during each consecutive 12-month period. During each enrollment period, the health maintenance organization shall accept up to its capacity as determined by the organization and submitted to the commissioner not less than 60 days before the commencement of the enrollment period, individuals in the order in which they apply for enrollment in a manner that does not unfairly discriminate on the basis of age, sex, race, health, or economic status. The commissioner may waive compliance by the organization with this open enrollment requirement for any 12-month period for which the organization demonstrates to the commissioner's satisfaction that either of the following will occur:

(a) It has enrolled, or will be compelled to enroll, a disproportionate number of individuals who are likely to utilize its services more often than an actuarially determined average as determined under rules promulgated by the commissioner, and enrollment during an open enrollment period of an additional number of those individuals will jeopardize its economic viability.

(b) If it maintained an open enrollment period, it would not be able to comply with the rules promulgated under this chapter.

(2) A health maintenance organization providing health maintenance services to specified groups of individuals may accept members of the groups before accepting other individuals in the order in which they apply.

(3) A health maintenance organization which, under this section, enrolls individuals who are not members of a group may rate this nongroup membership on the basis of actual and credible loss experience.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3539 Nongroup contract; exclusion or limitation; preexisting condition; renewal or continuation of nongroup contract or group contract; guaranteed renewal; healthy lifestyle program; "group" defined.

Sec. 3539. (1) For an individual covered under a nongroup contract or under a contract not covered under subsection (2), a health maintenance organization may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the health maintenance contract.

(2) A health maintenance organization shall not exclude or limit coverage for a preexisting condition for an individual covered under a group contract.

(3) Except as provided in subsection (5), a health maintenance organization that has issued a nongroup contract shall renew or continue in force the contract at the option of the individual.

(4) Except as provided in subsection (5), a health maintenance organization that has issued a group contract shall renew or continue in force the contract at the option of the sponsor of the plan.

(5) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health maintenance organization no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(6) A health maintenance organization is not required to continue a healthy lifestyle program or to continue any incentive associated with a healthy lifestyle program, including, but not limited to, goods, vouchers, or equipment.

(7) As used in this section, "group" means a group of 2 or more subscribers.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3541 Advocation by health professional.

Sec. 3541. A health maintenance organization shall not prohibit or discourage a health professional from advocating on behalf of an enrollee for appropriate medical treatment options pursuant to the grievance procedure in section 2213 or the patient's right to independent review act or from discussing with an enrollee or provider any of the following:

(a) Health care treatments and services.

(b) Quality assurance plans required by law, if applicable.

(c) The financial relationships between the health maintenance organization and the health professional including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3542 Inducement to health professional prohibited; exception.

Sec. 3542. (1) A health maintenance organization shall not use any financial incentive or make any payment to a health professional that acts directly or indirectly as an inducement to deny, reduce, limit, or delay specific medically necessary and appropriate services.

(2) Subsection (1) does not prohibit payment arrangements that are not tied to specific medical decisions or prohibit the use of risk sharing as otherwise authorized in this chapter.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
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500.3543 Third party administrator.

Sec. 3543. (1) With the commissioner's approval, a health maintenance organization may own or invest in a third party administrator. The commissioner shall grant approval upon being satisfied that all of the following conditions are met:

(a) The third party administrator is incorporated as a distinct legal entity under the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098, the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, or the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200.

(b) The third party administrator has a certificate of authority issued pursuant to the third party administrator act, 1984 PA 218, MCL 550.901 to 550.962.

(c) Based on generally accepted accounting principles, the proposed or operating third party administrator is financially sound and maintains adequate working capital.

(d) The investment in the third party administrator by the health maintenance organization does not endanger the continued operation of the health maintenance organization.

(e) The third party administrator maintains financial records for its activities separate or separable from the financial records of the health maintenance organization.

(2) Except as otherwise provided in this chapter, a third party administrator operating under this section is fully subject to the third party administrator act, 1984 PA 218, MCL 550.901 to 550.962. Neither this section nor the operation of the third party administrator as a separate legal entity diminishes the commissioner's authority under this act or other laws regulating the health maintenance organization or their parent companies.

(3) An individual covered under a plan administered by a third party administrator operating under this section is not liable for incurred medical expenses for covered services if the plan sponsor continues to pay the medical expenses that are eligible for payment.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3545 Acquisition of obligations from another managed care entity.

Sec. 3545. With the commissioner's prior approval, a health maintenance organization may acquire obligations from another managed care entity. The commissioner shall not grant prior approval unless the commissioner determines that the transaction will not jeopardize the health maintenance organization's financial security.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3547 Health care service operations; visitation or examination by commissioner; consultation with enrollees; additional authority.

Sec. 3547. (1) The commissioner at any time may visit or examine the health care service operations of a health maintenance organization and consult with enrollees to the extent necessary to carry out the intent of this chapter.

(2) In addition to the authority granted under chapter 2, the commissioner:

(a) Shall have access to all information of the health maintenance organization relating to the delivery of health services, including, but not limited to books, papers, computer databases, and documents, in a manner that preserves the confidentiality of the health records of individual enrollees.

(b) May require the submission of information regarding a proposed contract between a health maintenance organization and an affiliated provider as the commissioner considers necessary to assure that the contract is in compliance with this chapter.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3548 Maintenance of books, records, and files; funds and assets.

Sec. 3548. (1) A health maintenance organization shall keep all of its books, records, and files at or under the control of its principal place of doing business in this state, and shall keep a record of all of its securities, notes, mortgages, or other evidences of indebtedness, representing investment of funds at its principal place of doing business in this state in the same manner as provided for in section 5256.

(2) A health maintenance organization shall maintain financial records for its health maintenance activities separate from the financial records of any other operation or activity carried on by the person licensed under this chapter to operate the health maintenance organization.

(3) A health maintenance organization shall hold and maintain legal title to all assets, including cash and investments. Health maintenance organization funds and assets shall not be commingled with affiliates or other entities in pooling or cash management type arrangements. All health maintenance organization assets shall be held separate from all other activities of other members in a holding company system.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3549 Disciplinary action; notice to board.

Sec. 3549. A health maintenance organization shall notify the appropriate board as to any disciplinary action taken by the health maintenance organization for any of the grounds under section 16221 of the public health code, 1978 PA 368, MCL 333.16221, that results in a change of employment status or limitations on scope of participation of a health professional under contract to or directly employed by the health maintenance organization, including an offer by the health maintenance organization to permit the health professional to resign instead of the health maintenance organization taking disciplinary action against the health professional. The notice shall contain a summary of the information pertinent to the change and shall be transmitted in writing to the appropriate board within 30 days after the change occurs. As used in this section, “board” means a licensing board created under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3551 Health maintenance organization; net worth.

Sec. 3551. (1) A health maintenance organization's minimum net worth shall be determined using accounting procedures approved by the commissioner that ensure that a health maintenance organization is financially and actuarially sound.

(2) A health maintenance organization licensed under former part 210 of the public health code, 1978 PA 368, on the effective date of this chapter that automatically received a certificate of authority under section 3505(1) shall possess and maintain unimpaired net worth as required under former section 21034 of the public health code, 1978 PA 368, until the earlier of the following:

(a) The health maintenance organization attains a level of net worth as provided in subsection (3) at which time the health maintenance organization shall continue to maintain that level of net worth.

(b) December 31, 2003.

(3) A health maintenance organization applying for a certificate of authority on or after the effective date of this chapter and a health maintenance organization wishing to maintain a certificate of authority in this state after December 31, 2003 shall possess and maintain unimpaired net worth in an amount determined adequate by the commissioner to continue to comply with section 403 but not less than the following:

(a) For a health maintenance organization that contracts or employs providers in numbers sufficient to provide 90% of the health maintenance organization's benefit payout, minimum net worth is the greatest of the following:

(*i*) $1,500,000.00.

(*ii*) Four percent of the health maintenance organization's subscription revenue.

(*iii*) Three months' uncovered expenditures.

(b) For a health maintenance organization that does not contract or employ providers in numbers sufficient to provide 90% of the health maintenance organization's benefit payout, minimum net worth is the greatest of the following:

(*i*) $3,000,000.00.

(*ii*) Ten percent of the health maintenance organization's subscription revenue.

(*iii*) Three months' uncovered expenditures.

(4) The commissioner shall take into account the risk-based capital requirements as developed by the national association of insurance commissioners in order to determine adequate compliance with section 403 under this section.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3553 Minimum deposit requirements.

Sec. 3553. (1) Minimum deposit requirements for a health maintenance organization shall be determined as provided under this section and using accounting procedures approved by the commissioner that ensure that a health maintenance organization is financially and actuarially sound.

(2) A health maintenance organization licensed under former part 210 of the public health code, 1978 PA 368, on the effective date of this chapter that automatically received a certificate of authority under section 3505(1) shall possess and maintain a deposit as required under former section 21034 of the public health code, 1978 PA 368, until the earlier of the following:

(a) The health maintenance organization attains the level of deposit as provided in subsection (3) at which time the health maintenance organization shall continue to maintain that level of deposit.

(b) December 31, 2001.

(3) A health maintenance organization applying for a certificate of authority on or after the effective date of this chapter and a health maintenance organization wishing to maintain a certificate of authority in this state after December 31, 2001 shall possess and maintain a deposit in an amount determined adequate by the commissioner to continue to comply with section 403 but not less than $100,000.00 plus 5% of annual subscription revenue up to a $1,000,000.00 maximum deposit.

(4) The deposit required under this section shall be made with the state treasurer or with a federal or state chartered financial institution under a trust indenture acceptable to the commissioner for the sole benefit of the subscribers and enrollees in case of insolvency.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3555 Financial plan.

Sec. 3555. A health maintenance organization shall maintain a financial plan evaluating, at a minimum, cash flow needs and adequacy of working capital. The plan shall do all of the following:

(a) Demonstrate compliance with all health maintenance organization financial requirements provided for in this chapter.

(b) Provide for adequate working capital, which shall not be negative at any time. The commissioner may establish a minimum working capital requirement for a health maintenance organization to ensure the prompt payment of liabilities.

(c) Identify the means of achieving and maintaining a positive cash flow, including provisions for retirement of existing or proposed indebtedness.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3557 Notice of changes in operations.

Sec. 3557. A health maintenance organization shall file notice with the commissioner of any substantive changes in operations no later than 30 days after the substantive change in operations. A substantive change in operations includes, but is not limited to, any of the following:

(a) A change in the health maintenance organization's officers or directors. In addition to the notification, the health maintenance organization shall file a disclosure statement on a form prescribed by the commissioner for each newly appointed or elected officer or director.

(b) A change in the location of corporate offices.

(c) A change in the organization's articles of incorporation or bylaws. A copy of the revised articles of incorporation or bylaws shall be included with the notice.

(d) A change in contractual arrangements under which the health maintenance organization is managed.

(e) Any other significant change in operations.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3559 Reinsurance contract or plan; purpose; filing; approval; coverage.

Sec. 3559. (1) Subject to subsection (2), a health maintenance organization shall obtain a reinsurance contract or establish a plan of self-insurance as may be necessary to ensure solvency or to protect subscribers in the event of insolvency. A reinsurance contract shall be with an insurer that is authorized or eligible to transact insurance in Michigan.

(2) A reinsurance contract or plan under subsection (1) shall be filed for approval with the commissioner not later than 30 days after the finalization of the contract or plan. A reinsurance contract or plan shall clearly state all services to be received by the health maintenance organization. A reinsurance contract or plan shall be considered approved 30 days after it is filed with the commissioner unless disapproved in writing by the commissioner before the expiration of those 30 days.

(3) A health maintenance organization shall maintain insurance coverage to protect the health maintenance organization that includes, at a minimum, fire, theft, fidelity, general liability, errors and omissions, director's and officer's liability coverage, and malpractice insurance. A health maintenance organization shall obtain the commissioner's prior approval before self-insuring for these coverages.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)

500.3561 Insolvency; continuation of benefits.

Sec. 3561. A health maintenance organization shall have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to any member who is confined on the date of insolvency in an inpatient facility until his or her discharge from that facility. Continuation of benefits in the event of insolvency is satisfied if the health maintenance organization has at least 1 of the following, as approved by the commissioner:

(a) A financial guarantee contract insured by a surety bond issued by an independent insurer with a secure rating from a rating agency that meets the requirements of section 436a(1)(p).

(b) A reinsurance contract issued by an authorized or eligible insurer to cover the expenses to be paid for continued benefits after an insolvency.

(c) A contract between the health maintenance organization and its affiliated providers that provides for the continuation of provider services in the event of the health maintenance organization's insolvency. A contract under this subdivision shall provide a mechanism for appropriate sharing by the health maintenance organization of the continuation of provider services as approved by the commissioner and shall not provide that continuation of provider services is solely the responsibility of the affiliated providers.

(d) An irrevocable letter of credit.

(e) An insolvency reserve account established with a federal or state chartered financial institution under a trust indenture acceptable to the commissioner for the sole benefit of subscribers and enrollees, equal to 3 months' premium income.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3563 Insolvency; allocation of group coverage to health maintenance organizations and insurers participating in enrollment process; allocation of group coverage to health maintenance organizations or insurers within service area; nongroup coverage; reassignment of enrollees of insolvent organization contracting with state funded health care program.

Sec. 3563. (1) If a health maintenance organization becomes insolvent, upon the commissioner's order all other health maintenance organizations and health insurers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the insolvent health maintenance organization's and health insurer's group enrollees a 30-day enrollment period beginning on the date of the commissioner's order. Each health maintenance organization and health insurer shall offer the insolvent health maintenance organization's enrollees the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other health maintenance organization or health insurer had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health maintenance organizations or health insurers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage that is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(3) The commissioner shall allocate equitably the insolvent health maintenance organization's nongroup enrollees who are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer the nongroup enrollees the health maintenance organization's existing coverage without a preexisting condition limitation for individual or conversion coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at

rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into 1 group for rating and coverage purposes.

(4) If a health maintenance organization that contracts with a state funded health care program becomes insolvent, the commissioner shall inform the state agency responsible for the program of the insolvency. Notwithstanding any other provision of this section, enrollees of an insolvent health maintenance organization covered by a state funded health care program may be reassigned in accordance with state and federal statutes governing the particular program.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3565 Cancellation of contract by nongroup subscriber.

Sec. 3565. (1) A nongroup subscriber, in addition to other rights available to revoke an offer, may cancel a health maintenance contract within 72 hours after signing. Any deposit or prepayment made shall be refunded within 30 days of receipt of the notice of cancellation. A nongroup subscriber shall be responsible for payment of reasonable fees for any services received during the 72 hours. Fees may be deducted from the deposit or prepayment before the refund is made.

(2) Cancellation shall occur when written notice of cancellation is mailed or hand-delivered to the organization or its agent or representative.

(3) Notice of cancellation shall be sufficient if it indicates the intention of the person not to be bound by the contract or application.

(4) The right of cancellation shall appear in boldfaced type on the same page the individual subscriber signs to bind the contract.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3567 Cancellation of contract with nongroup enrollee by health maintenance organization.

Sec. 3567. (1) A health maintenance contract shall clearly delineate all conditions under which the health maintenance organization may cancel coverage for an enrollee.

(2) A health maintenance contract for nongroup subscribers shall specify an enrollee's rights and options in the case of a proposed amendment or change in the contract or the rate charged.

(3) Continued prepayment by the subscriber during the period of appeal, and while an appeal is in progress, does not constitute acceptance of the proposed amendment or rate change.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3569 Assumption of financial risk; "requiring an affiliated provider to assume financial risk" defined.

Sec. 3569. (1) Except as provided in section 3515(2), a health maintenance organization shall assume full financial risk on a prospective basis for the provision of health maintenance services. However, the organization may do any of the following:

(a) Require an affiliated provider to assume financial risk under the terms of its contract.

(b) Obtain insurance.

(c) Make other arrangements for the cost of providing to an enrollee health maintenance services the aggregate value of which is more than $5,000.00 in a year for that enrollee.

(2) If the health maintenance organization requires an affiliated provider to assume financial risk under the terms of its contract, the contract shall require both of the following:

(a) The health maintenance organization to pay the affiliated provider, including a subcontracted provider, directly or through a licensed third party administrator for health maintenance services provided to its enrollees.

(b) The health maintenance organization to keep all pooled funds and withhold amounts and account for them on its financial books and records and reconcile them at year end in accordance with the written agreement between the affiliated provider and the health maintenance organization.

(3) As used in this section, "requiring an affiliated provider to assume financial risk" means a transaction whereby a portion of the chance of loss, including expenses incurred, related to the delivery of health maintenance services is shared with an affiliated provider in return for a consideration. These transactions include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity agreements.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3571 State and federal health programs.

Sec. 3571. A health maintenance organization is not precluded from meeting the requirements of, receiving money from, and enrolling beneficiaries or recipients of state and federal health programs. A health maintenance organization that participates in a state or federal health program shall meet the solvency and financial requirements of this act, unless the health maintenance organization is in receivership or under supervision, but is not required to offer benefits or services that exceed the requirements of the state or federal health program. This section does not apply to state employee or federal employee health programs.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

Popular name: HMO

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3573 Operation of health care delivery system not meeting requirements of act; permitted conduct; limitations.

Sec. 3573. A person proposing to operate a system of health care delivery and financing that is to be offered to individuals, whether or not as members of groups, in exchange for a fixed payment and organized so that providers and the organization are in some part at risk for the cost of services in a manner similar to a health maintenance organization, but fails to meet the requirements set forth in this chapter, may operate such a system if the commissioner finds that the proposed operation will benefit persons who will be served by it. The operation shall be authorized and regulated in the same manner as a health maintenance organization under this chapter including the filing of periodic reports, except to the extent that the commissioner finds that the regulation is inappropriate to the system of health care delivery and financing. A person operating a system of health care delivery and financing under this section shall not advertise or solicit or in any way identify itself in a manner implying to the public that it is a health maintenance organization authorized under this chapter.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

REVISED JUDICATURE ACT OF 1961 (EXCERPT)
Act 236 of 1961

600.2950i Foreign protection order; validity; affirmative defenses.

Sec. 2950i. (1) A foreign protection order is valid if all of the following conditions are met:

(a) The issuing court had jurisdiction over the parties and subject matter under the laws of the issuing state, tribe, or territory.

(b) Reasonable notice and opportunity to be heard is given to the respondent sufficient to protect the respondent's right to due process. In the case of ex parte orders, notice and opportunity to be heard must be provided to the respondent within the time required by state or tribal law, and in any event within a reasonable time after the order is issued, sufficient to protect the respondent's due process rights.

(2) All of the following may be affirmative defenses to any charge or process filed seeking enforcement of a foreign protection order:

(a) Lack of jurisdiction by the issuing court over the parties or subject matter.

(b) Failure to provide notice and opportunity to be heard.

(c) Lack of filing of a complaint, petition, or motion by or on behalf of a person seeking protection in a civil foreign protection order.

History: Add. 2001, Act 206, Eff. Apr. 1, 2002.

REVISED JUDICATURE ACT OF 1961 (EXCERPT)
Act 236 of 1961

600.2950j Foreign protection order; subject to full faith and credit and enforcement; child custody or support provision.

Sec. 2950j. (1) A valid foreign protection order shall be accorded full faith and credit by the court and shall be subject to the same enforcement procedures and penalties as if it were issued in this state.

(2) A child custody or support provision within a valid foreign protection order shall be accorded full faith and credit by the court and shall be subject to the same enforcement procedures and penalties as any provision within a personal protection order issued in this state. This subsection shall not be construed to preclude law enforcement officers' compliance with the child protection law, 1975 PA 238, MCL 722.621 to 722.638.

History: Add. 2001, Act 206, Eff. Apr. 1, 2002.

REVISED JUDICATURE ACT OF 1961 (EXCERPT)
Act 236 of 1961

600.2950k Foreign protection order; issuance against petitioner and respondent; conditions; "spouse or intimate partner" defined.

Sec. 2950k. (1) A foreign protection order sought by a petitioner against a spouse or intimate partner and issued against both the petitioner and respondent is entitled to full faith and credit against the respondent and is enforceable against the respondent.

(2) A foreign protection order sought by a petitioner against a spouse or intimate partner and issued against both the petitioner and respondent is not entitled to full faith and credit and is not enforceable against the petitioner unless both of the following conditions are met:

(a) The respondent filed a cross- or counter-petition, complaint, or other written pleading seeking the foreign protection order.

(b) The issuing court made specific findings against both the petitioner and the respondent and determined that each party was entitled to relief.

(3) For purposes of this section, "spouse or intimate partner" means all of the following:

(a) Spouse.

(b) Former spouse.

(c) An individual with whom petitioner has had a child in common.

(d) An individual residing or having resided in the same household as petitioner.

(e) An individual with whom petitioner has or has had a dating relationship as that term is defined in section 2950.

History: Add. 2001, Act 206, Eff. Apr. 1, 2002.

REVISED JUDICATURE ACT OF 1961 (EXCERPT)
Act 236 of 1961

600.2950*l* Foreign protection order.

Sec. 2950*l*. (1) Law enforcement officers, prosecutors, and the court shall enforce a foreign protection order other than a conditional release order or probation order issued by a court in a criminal proceeding in the same manner that they would enforce a personal protection order issued in this state under section 2950 or 2950a or section 2(h) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, unless indicated otherwise in this section.

(2) A foreign protection order that is a conditional release order or a probation order issued by a court in a criminal proceeding shall be enforced pursuant to section 2950m of this act, section 15(1)(g) of chapter IV of the code of criminal procedure, 1927 PA 175, MCL 764.15, the uniform criminal extradition act, 1937 PA 144, MCL 780.1 to 780.31, or the uniform rendition of accused persons act, 1968 PA 281, MCL 780.41 to 780.45.

(3) A law enforcement officer may rely upon a copy of any protection order that appears to be a foreign protection order and that is provided to the law enforcement officer from any source if the putative foreign

protection order appears to contain all of the following:

(a) The names of the parties.

(b) The date the protection order was issued, which is prior to the date when enforcement is sought.

(c) The terms and conditions against respondent.

(d) The name of the issuing court.

(e) The signature of or on behalf of a judicial officer.

(f) No obvious indication that the order is invalid, such as an expiration date that is before the date enforcement is sought.

(4) The fact that a putative foreign protection order that an officer has been shown cannot be verified on L.E.I.N. or the NCIC national protection order file is not grounds for a law enforcement officer to refuse to enforce the terms of the putative foreign protection order, unless it is apparent to the officer that the putative foreign protection order is invalid. A law enforcement officer may rely upon the statement of petitioner that the putative foreign protection order that has been shown to the officer remains in effect and may rely upon the statement of petitioner or respondent that respondent has received notice of that order.

(5) If a person seeking enforcement of a foreign protection order does not have a copy of the foreign protection order, the law enforcement officer shall attempt to verify through L.E.I.N., or the NCIC protection order file, administrative messaging, contacting the court that issued the foreign protection order, contacting the law enforcement agency in the issuing jurisdiction, contacting the issuing jurisdiction's protection order registry, or any other method the law enforcement officer believes to be reliable, the existence of the foreign protection order and all of the following:

(a) The names of the parties.

(b) The date the foreign protection order was issued, which is prior to the date when enforcement is sought.

(c) Terms and conditions against respondent.

(d) The name of the issuing court.

(e) No obvious indication that the foreign protection order is invalid, such as an expiration date that is before the date enforcement is sought.

(6) If subsection (5) applies, the law enforcement officer shall enforce the foreign protection order if the existence of the order and the information listed under subsection (5) are verified, subject to subsection (9).

(7) If a person seeking enforcement of a foreign protection order does not have a copy of the foreign protection order, and the law enforcement officer cannot verify the order as described in subsection (5), the law enforcement officer shall maintain the peace and take appropriate action with regard to any violation of criminal law.

(8) When enforcing a foreign protection order, the law enforcement officer shall maintain the peace and take appropriate action with regard to any violation of criminal law. The penalties provided for under sections 2950 and 2950a and chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.1 to 712A.32, may be imposed in addition to a penalty that may be imposed for any criminal offense arising from the same conduct.

(9) If there is no evidence that the respondent has been served with or received notice of the foreign protection order, the law enforcement officer shall serve the respondent with a copy of the foreign protection order, or advise the respondent about the existence of the foreign protection order, the name of the issuing court, the specific conduct enjoined, the penalties for violating the order in this state, and, if the officer is aware of the penalties in the issuing jurisdiction, the penalties for violating the order in the issuing jurisdiction. The officer shall enforce the foreign protection order and shall provide the petitioner, or cause the petitioner to be provided, with proof of service or proof of oral notice. The officer also shall provide the issuing court, or cause the issuing court to be provided, with a proof of service or proof of oral notice, if the address of the issuing court is apparent on the face of the foreign protection order or otherwise is readily available to the officer. If the foreign protection order is entered into L.E.I.N. or the NCIC protection order file, the officer shall provide the L.E.I.N. or the NCIC protection order file entering agency, or cause the L.E.I.N. or NCIC protection order file entering agency to be provided, with a proof of service or proof of oral notice. If there is no evidence that the respondent has received notice of the foreign protection order, the respondent shall be given an opportunity to comply with the foreign protection order before the officer makes a custodial arrest for violation of the foreign protection order. The failure to comply immediately with the foreign protection order is grounds for an immediate custodial arrest. This subsection does not preclude an arrest under section 15 or 15a of chapter IV of the code of criminal procedure, 1927 PA 175, MCL 764.15 and 764.15a, or a proceeding under section 14 of chapter XIIA of the code of criminal procedure, 1927 PA 175, MCL 712A.14.

(10) A law enforcement officer, prosecutor, or court personnel acting in good faith are immune from civil and criminal liability in any action arising from the enforcement of a foreign protection order. This immunity

does not in any manner limit or imply an absence of immunity in other circumstances.

History: Add. 2001, Act 197, Eff. Apr. 1, 2002.

REVISED JUDICATURE ACT OF 1961 (EXCERPT)
Act 236 of 1961

600.2950m Foreign protection order; violation as misdemeanor; penalty.

Sec. 2950m. A person who violates a foreign protection order that is a conditional release order or a probation order issued by a court in a criminal proceeding is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of $500.00, or both.

History: Add. 2001, Act 197, Eff. Apr. 1, 2002.